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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/18/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L4/5 decompression

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic spine surgeon, practicing neurosurgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Pre-authorization determination and physician advisor report 03/09/12
Pre-authorization determination letter and physician advisor report 04/13/12
Utilization review reconsideration determination and physician advisor report 05/08/12
Operative report right sacroiliac joint block 01/24/12
Office visit notes Dr. 05/24/11-02/28/12
Pre-authorization request/fax cover sheet 03/06/12
MRI lumbar spine 06/10/11
Pre-authorization reconsideration request/fax cover sheet 04/05/12
Office visit notes 01/25/10-08/17/10
MRI lumbar spine 01/15/10
Certification medical necessity L4-5 laminectomy discectomy 06/01/10
TBA claim notification letter 01/07/10
Request for additional information 08/25/10
Case management note 02/25/10
Certification medical necessity MRI lumbar spine 06/02/11
Operative report L4-5 laminectomy with bilateral medial facetectomies and bilateral discectomies and bilateral L5 foraminotomies 06/16/10
History and physical report 06/16/10
Office notes Dr. 01/19/10 and 01/05/10

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a whose date of injury is xx/x/xx. The claimant reports she was working when she turned and "pulled her back." The next morning she awoke with numbness over the posterior right leg to the calf. After failing a course of conservative care, the claimant underwent L4-5 laminectomy discectomy on 06/16/10. Following surgery the claimant participated in physical therapy. Records indicate the claimant initially did well following surgery but subsequently returned on 05/24/11 with right leg pain in a different radicular pattern. MRI of the lumbar spine on 06/10/11 revealed post-op changes at L4-5 with epidural fibrosis surrounding the transiting right L5 nerve root. There was no evidence of recurrent disc herniation. The central canal and neural foramina were grossly patent. There were minimal degenerative changes noted. Records indicate claimant tried medications, physical therapy and injections including SI joint injection without benefit. She is recommended to undergo reoperation.

An initial pre-auth UR review on 03/09/12 determined request for repeat surgery of right L4-5 decompression is not medically necessary. It is noted the claimant underwent decompressive surgery in 06/10 with improved symptomatology. Postoperative MRI showed no recurrent disc herniation. The claimant was seen by Dr. and reported right leg pain, but records provided no physical examination findings to confirm radiculopathy. It was noted the claimant was treated with pain medications, physical therapy, NSAIDs, and injections, but it was unclear the response to conservative treatment although it appears to not have been successful. Given failure to document or confirm objective physical examination findings confirming radiculopathy or without recent MRI confirming nerve root impingement consistent with current evidence based guidelines and Official Disability Guidelines the proposed surgery cannot be approved as indicated and medically necessary.

A preauthorization request for right L4-5 decompression was reviewed on 04/13/12 and the request was determined as not medically necessary. The reviewer noted the submitted clinical record consists of follow-up notes from Dr. which fail to provide detailed physical examinations indicating the presence of active / recurrent lumbar radiculopathy. Further, the record contains no supporting documents establishing failure of interval conservative treatment to include physical therapy and interventional procedures. In absence of appropriate supporting documentation and noting lack of detailed physical examination, the request for repeat surgery of right L4-5 decompression is not medically necessary and not supported by ODG.

A request for reconsideration of utilization review determination concerning right L4-5 decompression was reviewed on 05/08/12, and it was determined the requested treatment does not meet medical necessity guidelines. It was noted the claimant has failed injections, medications and physical therapy; however, recent comprehensive clinical evidence of recurrent radiculopathy has not been documented. In addition, imaging studies do not demonstrate positive nerve root compression other than epidural fibrosis, and non-certification was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, the request for right L4-5 decompression is not supported as medically necessary. The claimant is noted to have sustained an injury to low back on xx/xx/xx. She is status post L4-5 laminectomy and discectomy performed 06/16/10. Records indicate the claimant initially did well following surgery, but subsequently returned in 2011 with right leg pain. Repeat MRI of lumbar spine on 06/10/11 revealed postoperative changes at L4-5 with epidural fibrosis surrounding the transiting right L5 nerve root, but no evidence of recurrent disc herniation, and no evidence of central spinal canal or foraminal stenosis. The clinical records submitted for review do not include a detailed physical

examination with findings consistent with lumbar radiculopathy including evaluation of motor, sensory and reflex changes. As such, the request does not meet criteria as specified in ODG for discectomy / laminectomy, and previous denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)